

Appendix 12  
Prior Authorization Spell of Illness Attachment (PA/SOIA) Sample  
(Physical Therapy)

Mail To:

E.D.S. FEDERAL CORPORATION  
Prior Authorization Unit  
Suite 88  
6406 Bridge Road  
Madison, WI 53784-0088

**PA/SOIA**

**PRIOR AUTHORIZATION  
SPELL OF ILLNESS ATTACHMENT**  
(Physical, Occupational, Speech Therapy)

1. Complete this form
2. Attach to PA/RF  
(Prior Authorization Request Form)
3. Mail to EDS

**RECIPIENT INFORMATION**

① Recipient LAST NAME	② Im FIRST NAME	③ A. MIDDLE INITIAL	④ 1234567890 MEDICAL ASSISTANCE ID NUMBER	⑤ 29 AGE
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**PROVIDER INFORMATION**

⑥ I.M. Performing PT THERAPIST'S NAME AND CREDENTIALS	⑦ 12345600 THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	⑧ ( XXX ) XXX - XXXX THERAPIST'S TELEPHONE NUMBER
⑨ I.M. Referring MD REFERRING/PRESCRIBING PHYSICIAN'S NAME		

- A. ☒ Physical Therapy SOI    ☐ Occupational Therapy SOI    ☐ Speech Therapy SOI
- B. Provide a description of the recipient's diagnosis and problems.  
Indicate the functional regression which has occurred and the potential to reach the previous skill level.
- PT fix'd pelvis on 6/18/94. Had been amb c cane c guarded to min assist of 1 on the unit. Was transferring c standby assist only. No % pain. Therapy initiated 6/25/94. PT requires max assist of 1 c walker to amb. Transfers require max of 1. % pain is constant c any movement. Expect PT to return to previous amb/transfer status and to be maintained by restorative nursing.
- C. Attach a copy of the recipient's Therapy Plan of Care, including a current evaluation.
- D. What is the anticipated end date of the spell of illness?
- E. Supply the physician's dated signature on either the Therapy Plan of Care or the Physician's Order Sheet.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM  
THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

F. \_\_\_\_\_  
Signature of Prescribing Physician  
(A copy of the Physician's Order Sheet is acceptable)

MM/DD/YY

Date

G. \_\_\_\_\_  
Signature of Therapist Providing Evaluation/Treatment

MM/DD/YY

Date